

**CLAIM -- VOUCHER**

State Form 11294 (R 4/1-96)

Approved by State Board of Accounts, 1996.

Name of agency personnel who prepared this claim.

Name:

Carl Heck

Phone:

317/696-5520

**INSTRUCTIONS:** This agency is requesting disclosure of your Social Security Number in accordance with I.C. 4-1-8

VENDOR INFORMATION						AGENCY INFORMATION			
Document Number		Date (Month, Day, Year)				Agency Name <b>Indiana State Department of Agriculture</b>			
Vendor Name						Agency Number <b>036</b>			
Address (Number, Street)						Social Security Number		1099 CODE	
Address ( P. O Box Number)						Federal I. D. Number		1099 CODE	
City, State, and ZIP Code (00000-0000)						Vendor Number			
<b>AREA BELOW TO BE COMPLETED BY AGENCY.</b>									
DATE	AMOUNT	FUND	OBJECT	CENTER	LOAN/INV/NBR	QTY.	UNIT	DESCRIPTION	
		6000	578200	181400				Organic Certification Cost-Share Reimburs-	
								ment	
								Date of Service: 10/1/02-9/30/06	
GROSS AMOUNT \$					Furnished to: (Name of State Agency) <b>Indiana State Department of Agriculture</b>				
I certify that this claim is correct and valid and is a proper charge against the State Agency, Fund, and Center indicated.									
Authorized Signature of State Agency					Date (Month, Day, Year)				
Pursuant to the provisions and penalties of Indiana Code 5-1-11-10-1, I hereby certify that the foregoing Fund and Center is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.									
Signature of Vendor					Date (Month, Day, Year)				